STATE OF MICHIGAN

COURT OF APPEALS

In re Estate of James Nicholas Sawaya, Deceased.

PAMELA SAWAYA SOBIESKI,

Plaintiff-Appellant,

v

NARSIMHA R. GOTTAM, M.D.,

Defendant-Appellee,

and

DMC HARPER HOSPITAL,

Defendant.

UNPUBLISHED
February 21, 2003

No. 236394
Wayne Circuit Court
LC No. 99-906090-NH

Before: Markey, P.J., and Smolenski and Meter, JJ.

PER CURIAM.

Plaintiff Pamela Sawaya Sobieski appeals as of right the trial court's order granting defendant's[1] summary disposition motion regarding her medical malpractice claims. We affirm.

This Court reviews the grant of summary disposition de novo. *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999). Whether a witness is qualified to render an expert opinion and the actual admissibility of the expert's testimony are within the trial court's discretion; therefore, the trial court's decision is reviewed for abuse of that discretion. *Tate v Detroit Receiving Hosp*, 249 Mich App 212, 215; 642 NW2d 346 (2002). An abuse of discretion will be found only when the result is "so palpably and grossly violative of fact and logic that it evidences not the exercise of will but perversity of will, not the exercise of judgment but

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[1] DMC Harper Hospital was dismissed with prejudice from this case. Any references to "defendant" refer to Narsimha R. Gottam, M.D. only.

defiance thereof, not the exercise of reason but rather of passion or bias." *Dep't of Transportation v Randolph*, 461 Mich 757, 768; 610 NW2d 893 (2000) (citations omitted).

Plaintiff's first issue on appeal is that the trial court erred in determining that plaintiff did not provide scientific evidence establishing a causal relationship between's defendant's conduct and decedent's death. We disagree.

A summary disposition motion under MCR 2.116(C)(10) asserts there is no genuine issue of material fact and the moving party is entitled to judgment or partial judgment as a matter of law. *Maiden*, *supra* at 120. When an MCR 2.116(C)(10) summary disposition motion is made, the opposing party must set forth specific facts showing a genuine issue for trial. *Maiden*, *supra* at 121. The trial court must consider affidavits, pleadings, depositions, admissions, and documentary evidence submitted by the parties. *Id*. at 120; MCR 2.116(G)(5). Only substantively admissible evidence must be considered, and this evidence must be viewed in the light most favorable to the opposing party. *Maiden*, *supra* at 120; MCR2.116(G)(6).

In a medical malpractice case, the plaintiff "'bears the burden of proving: (1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury.'" *Cox v Flint Bd of Hosp Managers*, 467 Mich 1, 10; 651 NW2d 356 (2002), quoting *Wischmeyer v Schanz*, 449 Mich 469, 484; 536 NW2d 760 (1995). Causation entails cause in fact and proximate cause. *Skinner v Square D Co*, 445 Mich 153, 163; 516 NW2d 475 (1994). Cause in fact requires proving "'but for' the defendant's actions, the plaintiff's injury would not have occurred." *Id*. Proximate cause "involves examining the foreseeability of consequences, and whether a defendant should be held legally responsible for such consequences." *Id*. Circumstantial evidence "must facilitate reasonable inferences of causation, not mere speculation." *Id*. at 164. The proofs presented by the plaintiff must "amount to a reasonable likelihood of probability rather than a possibility" that defendant's actions caused the injury. *Id*. at 166.

> "As a theory of causation, a conjecture is simply an explanation consistent with known facts or conditions, but not deducible from them as a reasonable inference. There may be 2 or more plausible explanations as to how an event happened or what produced it; yet, if the evidence is without selective application to any 1 of them, they remain conjectures only. On the other hand, if there is evidence which points to any 1 theory of causation, indicating a logical sequence of cause and effect, then there is a juridical basis for such a determination, notwithstanding the existence of other plausible theories with or without support in the evidence." [*Id*., quoting *Kaminski v Grand Trunk W R Co*, 347 Mich 417, 422; 79 NW2d 899 (1956).]

It is not sufficient if a factually supported causation theory is just as possible as another theory. *Id*. at 164-165. Additionally, a trial court must ensure that all scientific testimony is reliable. *Tobin v Providence Hosp*, 244 Mich App 626, 646; 624 NW2d 548 (2001).

In this case, we find that plaintiff's circumstantial evidence did not afford a reliable basis from which reasonable minds could infer that more probably than not, but for defendant's actions decedent would not have developed a gastrointestinal bleed. Plaintiff's causation theory is that due to decedent's medical history and circumstances, including withdrawals from cocaine

and alcohol abuse, decedent was already in an agitated state, and the additional anxiety over the cardiac catheterization caused his gastrointestinal bleed. Plaintiff alleges that defendant should have known that decedent could have had ulcers and that the cardiac catheterization could adversely affect this condition.

In support of this theory, plaintiff presented the expert testimony of Dr. G. John DiGregorio who testified that anxiety and localized bleeding at the insertion site can be effects of cardiac catheterization, and that he believed that the stress over this procedure caused decedent's gastrointestinal bleed. However, DiGregorio is not a board certified internist or cardiologist. Therefore, DiGregorio was not qualified to testify against defendant. MCL 600.2169.

Also, even if DiGregorio was allowed to testify, he admitted that there was no research or medical literature which concluded that cardiac catheterizations could cause anxiety severe enough to cause or exacerbate stress ulcers. Similarly, while another of plaintiff's experts, Dr. Harry Cohen, a cardiologist, testified that he had heard of people developing gastrointestinal bleeding from undergoing cardiac catheterization, he could not reference any literature to support this. Additionally, plaintiff's last expert, Dr. David Isaacs, an internist who does not do cardiac catheterizations, testified that he would not recommend performing such a procedure on a patient going through withdrawals because the patient is likely to be restless and agitated; however, his concern was that the patient's condition could cause bleeding at the catheter's insertion point, not gastrointestinal bleeding. Therefore, we do not find that the testimony was "supported by appropriate objective and independent validation based on what is known, e.g., scientific and medical literature." *Tobin*, *supra* at 647.

Furthermore, negligence is not established if the evidence lends equal support to inconsistent conclusions or is equally consistent with contradictory hypotheses. *Skinner*, *supra* at 166-167. DiGregorio stated that cocaine abuse alone can cause gastrointestinal bleeding and that decedent had anxiety before the possibility of a cardiac catheterization was raised. Also, DiGregorio cited a treatise which states that there are numerous causes for gastrointestinal bleeds. DiGregorio's opinion was nothing more than conjecture and did not eliminate the plausibility of other causes of decedent's gastrointestinal bleed. *Id.* at 163-164.

In this case, there are many hypotheses over what may have caused decedent's gastrointestinal bleed, and plaintiff's experts did not put forth reliable evidence that defendant's conduct was the cause in fact or the proximate cause. Accordingly, we conclude that the trial court did not err by granting summary disposition in favor of defendant for this reason regarding plaintiff's claims (a)-(d).

Plaintiff's second issue on appeal is that the trial court erred in granting defendant's summary disposition motion when the trial court did not rule on two of plaintiff's other claims which alleged that defendant was negligent by failing to (1) timely recognize and treat decedent's gastrointestinal bleeding, and (2) provide adequate blood volumes to decedent during the search for the bleeding's source. The trial court did not separately address these claims. Instead, it dismissed all of plaintiff's claims on the basis that she failed to present any reliable evidence that the cardiac catheterization caused decedent's gastrointestinal bleeding.

These other two claims involve the standard of care decedent should have received following the cardiac catheterization, about which only one of plaintiff's experts, Dr. Isaacs, who

was a board certified internist, testified. Defendant is a board certified internist and cardiologist. Plaintiff argues that defendant was acting as an internist in caring for decedent after the cardiac procedure, and, therefore, Isaacs was qualified to testify as to the standard of care. Defendant argues that he spends 90% of his time working as a cardiologist, treated decedent as a cardiologist, and never stepped out of his role as a cardiologist. Therefore, defendant contends, Isaacs was not qualified to testify against him because he is not a cardiologist.

In order to give expert testimony in a medical malpractice suit, the qualifications of the expert must match the qualifications of the defendant. *Decker v Flood*, 248 Mich App 75, 85; 638 NW2d 163 (2001); MCL 600.2169. MCL 600.2169(1) provides, in pertinent part,

> In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
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> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

"[T]he specialty requirement is tied to *the occurrence of the alleged malpractice* and not unrelated specialties that a defendant physician may hold." *Tate v Detroit Receiving Hosp*, 249 Mich App 212, 218; 642 NW2d 346 (2002) (emphasis added). For example, the *Tate* Court noted that if a doctor who is board certified in both gynecology and emergency medicine sets a broken leg, the alleged malpractice would involve the doctor's specialty in emergency medicine. *Id*. at 219 n1. In *Tate*, the malpractice action was based on an untreated urinary tract infection. Thus, the Court concluded that the specialty of internal medicine was involved. *Id*. at 221. The plaintiff did not allege that the decedent was receiving care in the critical care unit or that the malpractice related to the decedent's kidneys, both of which would implicate other specialties. *Id*. at 220 n 2.

Therefore, the question in this case is whether the alleged malpractice in plaintiff's claims (e) and (f) relate to internal medicine generally or cardiology specifically. Plaintiff alleges that defendant was negligent in failing to diagnose the gastrointestinal bleed (claim e), and in not giving decedent additional blood sooner during the search for the source of the bleeding (claim f). We find that these claims involve the field of internal medicine, not cardiology. Therefore, Isaacs was qualified under MCL 600.2169 to testify against defendant as to the appropriate standard of care.

However, because plaintiff did not present any evidence regarding defendant's failure to recognize the gastrointestinal bleed and give decedent a blood transfusion sooner was the cause in fact of decedent's death, we must affirm the trial court's grant of summary disposition in regards to plaintiff's claims (e) and (f). Dr. Isaacs testified that decedent should have been given additional blood sooner because of the level to which his hematocrit level had dropped. Isaacs admitted that this would not have stopped the hemorrhage, but would only "buy time" while the source of the bleed was located. Isaacs also testified that defendant should have called in a gastroenterologist or a surgeon instead of trying to locate the source of the bleed himself.

Being an internist, Isaacs could not testify as to what the prognosis by a gastroenterologist or a surgeon would have been. Plaintiff failed to present substantial evidence from which a jury could conclude that more likely than not, but for defendant's conduct, decedent's death would not have occurred. *Skinner, supra* at 165. A mere possibility of such causation is not sufficient. *Id*.

Affirmed.

/s/ Jane E. Markey
/s/ Michael R. Smolenski
/s/ Patrick M. Meter